DPHHS-SLTC-135 b
(Rev. 12/2012)

STATE OF MONTANA
Department of Public Health and Human Services

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HCBS SERVICE PLAN SHORT FORM

Consumer Name:		Enrollment Date: Update:		Discharge	Readmits
Level of Care Evaluation Date:		Met LOC: YES☐ NO☐		Screened by: MPQH ☐ CMT ☐	
Social Security Number:	Medicaid ID#:	Phone Number:			
Physical Address:		Mailing address:			
Care Category ☐ Basic ☐ AR ☐ CC3		Email Address:			
Date of Birth:	Height:	Weight:	Sex:	Marital Status:	
Legal Representative: ☐ POA Type: _____ ☐ Legal Guardian ☐ Payee ☐ Other: _____					
Name	Address:			Phone:	
Significant Other Name(relationship):	Address:			Phone:	
Primary Health Care Provider:	Address:			Phone:	
Additional Health Care Providers & Type:	Address:			Phone:	
Additional Health Care Providers & Type:	Address:			Phone:	
OPA County:	Contact:			Phone:	
Pharmacy:				Phone:	
Residential Status: ☐ Lives Alone ☐ Lives with family/significant other ☐ Live in attendant	☐ Residential Habilitation; Type:_____ ☐ Other:				
Medicare ☐ Yes ☐ No	Medicare #	Effective Date (if Known):			
Medicare D:	Other Insurance:	Veteran or spouse of Veteran ☐ Yes ☐ No			
Primary Diagnosis:		ICD-9 or ICD 10:			

Brief Description of Need for Services
Medical and Psychosocial Summary/Allergies/Diagnosis/ICD9 Code

Service Plan

Discharge Date:

SIGNATURE SECTION

My plan addresses my needs and personal goals, including health and safety.	☐
I have made a free choice of services and qualified providers for each service included in my Service Plan.	☐
I have received a choice between institutional care and HCBS.	☐
I have received information on Abuse/Neglect and Exploitation and know how to report.	☐
I understand there is a service plan cost limit and a limit on the type of services available through the HCBS Program.	☐
I have participated in the development of this service plan and agree with it.	☐
The case management team has verified that HCBS services in this plan cannot be reimbursed by state plan Medicaid, Medicare or private insurance.	☐

Consumer Signature:	Date:
Legal Representative:	Date:
Primary Care Provider Signature:	Date:
CMT Nurse:	Date:
CMT: Social Worker:	Date:
Other:	Date: